DOCUMENT RESUME

ED 266 352 CG 018 832

AUTHOR Dye, Carol J.
TITLE What Business Do Psychologists Have in Long-Term Care Settings?
PUB DATE Aug 85
NOTE 5p.; Paper presented at the Annual Convention of the American Psychological Association (93rd, Los Angeles, CA, August 23-27, 1985).
PUB TYPE Viewpoints (120) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Clinical Psychology; *Consultants; *Environmental Influences; Nursing Homes; Older Adults; Problem Solving; Psychological Needs; *Psychological Services; Psychologists; *Quality of Life; *Staff Development
IDENTIFIERS *Long Term Care Facilities

ABSTRACT

In order to identify important clinical questions in long-term care settings for older adults, it may be helpful to examine the psychological consultant's role in these settings. A consultant is often faced with some staff members who think he has all the answers and by others who think he has none. The consultant may also encounter a strong attributional bias about the etiology of problems in long-term care settings. The staff may feel that the patient is the problem and that the patient's intrapsychic processes are the basis for difficulty. The consultant who notices this attributional bias must help the staff to consider other factors such as the impact of the past and present environment on behavior. In addition, many clinical questions presented to consultants deal with socially significant behaviors of residents rather than with clinically significant behaviors. While improvements in socially significant behaviors may benefit residents as well as make things easier for the staff, there must be some emphasis on addressing the clinical behaviors and the psychological needs of the older adult residents. Staff members need to learn about the effects of psychological problems on the functioning of residents and staff, and about the importance of improving the residents' quality of life. The psychological consultant must be skilled in organizational psychology, in providing continuing and in-service education, and in basic clinical abilities. (NRB)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED266352

WHAT BUSINESS DO PSYCHOLOGISTS HAVE IN LONG-TERM CARE SETTINGS?

Carol J. Dye

CG 018832

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it.

☑ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Carol J. Dye

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

Paper presented at the Annual Convention of the American Psychological Association, 93rd, Los Angeles, CA, August 23-27, 1985.

American Psychological Association Convention
Los Angeles, California
August 23-27, 1985

Discussion Panel: What business do psychologists have in long term care settings? Joyce Parr, Ph.D. Chairperson

What Clinical Questions Need to be Asked in Long Term Care Settings?

Carol J. Dye, Ph.D.

St. Louis V.A. Medical Center

What are the clinical questions that need to be asked in long term care settings for older adults? Perhaps one way to answer this question is to focus on the expectations of a psychological consultant in these settings and on some of the clinical questions typically encountered.

A consultant in any setting is often met with two paradoxical attitudes. Half of the staff imbues the consultant with magical qualities. Their perception is that single handedly the consultant can handle and resolve any problem presented. The other half of the staff doubts that the consultant has anything new to teach them. In the first instance questions are posed to the consultant in very vague terms, in the second case the clinical questions become challenges to the ability of the consultant. Of course both attitudes must be modified. An important skill of the consultant is to help staff and administrators to develop a psychological mindedness so as to best use the knowledge and skills that are offered. This is basic if a consultant will be successful at any level and a necessary first step toward asking the questions that need to be asked.

Another thing that happens is that most often there is a strong attributional bias about the etiology of problems that occur within the long term care setting. Clinical questions posed to consultants tend to imply that it is the resident that is the problem and that personality organization, long term neuroses, and other such intrapsychic processes are the basis for the difficulty. Usually, little thought is given to the impact of the environment or life events for the functioning of the individual. I do not mean to indicate that this attributional bias is seen only in long term care settings that care for older adults. This is a serious dispositional bias we all experience in clinical practice generally. However, with older adults in these settings we need to be especially careful of this bias because of the special impact of the problems of later life, the accumulation of life events and the impact of the congregate setting itself on the behavior of the older adult. So many things can come together in later life to modify the behavior of an otherwise normally functioning individual, and as physical or mental impairment increases, the environment becomes a powerful determinent of behavior. Powell Lawton has discussed this process as the environmental docility hypothesis at some length. So while clinical questions are typically presented to a psychological consultant with an attributional bias, that consultant must help staff to be more aware of the impact of the past and present environment on behavior to reframe the questions. This will take a good deal of skill on the part of the consultant because in many instances a focus on the role of staff and other aspects of a facility as causation for behavior will likely be a surprise to them and may produce defensive maneuvers and resistance. This is especially true where staff is under union control.

BEST COPY AVAILABLE

We can look at this question of what clinical questions need to be asked in yet another way. Many clinical questions typically presented to a consultant will deal with the socially significant behaviors of residents rather than the clinically significant behaviors. Things like control of excessive behaviors, such as crying out, pilfering, constantly asking when it's time to eat; loss of habits, such as inability to feed oneself or toilet or dress oneself; disturbing behaviors such as getting into the beds of other residents, constant pacing at night; or hostility shown in actual combativeness or verbal abuse are examples of problems typically brought to a consultant. Clinically significant behaviors are the psychological states experienced by the older adults themselves i.e. depression, obsessive thoughts, paranoia, anxiety, fear, etc. Also included would be the psychological reactions to prolonged physical disability and failing mental capacities. The socially significant behaviors are those that give the staff and administrator trouble and for which they typically hire a consultant. They are problems that agitate and upset other residents who in turn press staff and administrators for solutions. These are quite appropriate clinical questions to be asked of a consultant. Addressing these will likely result in more effective care by the staff. And, some of the socially significant problems will result in an improved quality of life for the individual older adult, i.e. relearning how to dress oneself will likely increase the individual's self esteem. Decreasing the amount of crying out that occurs in an older adult may improve the interaction of that individual with the staff because staff no longer has to spend time on the control of the shouting or perceives the resident less negatively and so on. But, not all of these have obvious positive benefits for the individual older adult and the basic purpose for referral is really for the benefit of the staff. There must be some emphasis in these settings on addressing the psychological needs of the older adults themselves. Depression and anxiety are frequently apparent in populations of older adults in long term care settings. Paranoia is also present but not so frequent. Often these disorders appear as or presage dementia. Careful diagnosis and treatment may result in the return of the older adult to the community in some cases. Even if this is not possible, an improvement in mental health is desirable to facilitate adjustment. So the clinical question that needs to be asked here is what was the real cause for the older adult entering the facility and what programs could help in alleviating the psychological distress of that person. Again this would include psychological reactions to chronic disability and illness.

A staff's awareness of the clinical problems experienced internally by their residents tends to be on a much lower level than of the external behaviors. And they are even less aware of what to do to help their residents or of how these internal states impact on their own functioning, since the relationships are so subtle. One thing is certain, however, and that is that the older adults themselves are more concerned about these things. And another thing is likely - that an improved quality of life for the older adult will more probably result if emphasis is put on these clinically significant questions. Consequently staffs need to learn about the ultimate effects of these psychological problems on the functioning of older adults themselves as well as the staff and of the importance of improving the quality of life for the older adults. Of course it may be in some cases staff members are not interested in addressing these clinically significant problems.

For example, a passive resident (because of depression) is easier to care for. If that is the case, the consultant must handle the additional problems and questions that apply to staff perceptions of the purpose and mission of the long term care setting within which they spend 8 or more hours a day. There are other necessary questions here - such as is it appropriate to reduce the withdrawal of an older adult to fully experience the negative aspects of their life in a long term care setting; or is it appropriate to reduce the hostility or anxiety that results in greater staff attention so that the older adult receives less attention when they are more passive and less active and demanding? Again the need to focus on the milieu within the long term care setting becomes obvious here.

I think you can appreciate the complexity of asking the right type of clinical questions and the complexity of the solutions in this setting. The psychological consultant will need skills in organizational psychology, in providing continuing education and in-service training as well as basic clinical abilities. There may be the need for the psychological consultant to suggest the provision of a great many more services than those for which originally hired. In essence then there is the need to address the issues of the total environment. Those are the questions that need to be asked -- how does the environment (in any of its aspects) of the long term care setting contribute to the status of the resident. How can any environment reduce negative behavior and optimize functioning? How can all parties in the long term care setting - administrators, staff and residents work together more effectively to create a better environment for all? How can there be proper focus on the internal psychological states of the older adults there so as to improve their quality of life? If these questions are asked and addressed in all their implications, then the psychological health of the older adult residents will be addressed while at the same time the work of the staff can become more enjoyable and meaningful and, the psychological consultant is the key to this process.